



# REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

FISCAL ADI	NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES FISCAL ADMINISTRATION	F HUMAN S	ERVICES		The Village Fa	The Village Family Service Center Address Line 1: PO Box 9859	¥			I hereby certify that this request accurate reflects expenditures for services rendered in
SFN 1/63 (Rev. 2-2017)	W. 2-2017)				Line 2:					accordance with an agreement between th vendor/provider organization or agence
(See reverse for instructions on completing this form).	n completing this form).				City:			State:	Zip Code:	/e and the North
CONTRACT INFORMATION			Column A	Column R	Column	2	Column E	Column F	Column G	fund requirements have been complied with an that such compliance is documented for aud
Description of Service:	I			Constitution	Column	Column	Total Matching Expenditures	Matching Expenditures	Cumulative Matching	purposes. Is this the final reimbursement request
Alternatives to			Total Expenditures	Expenditures Claimed	Cumulative	Total Contract Award	(Including In-Kind, if	(Including In-Kind, if	Expenditures (Including	for this contract? (Please check a box)  X  No  Yes
Abortion			Previously	This Billing	To Date	(Including all	Allowable)	Allowable)	In-Kind, if Allowable)	Payee Signature:
	Expenditure Classification	tion	Claimed	Period	Columns A & B	Amendments)	Reported	Period	to Date	(Inner conver
	Salanes & Fringe Benefit (Employees Only)	nployees	\$57,348.00	\$3,292.00	\$60,640.00	\$116,593.00			Coluiting	10-0-16
	Travel					\$1,275.00				Payee Telephone Number:
DHS Contract Number:	Consultation Services		\$270,290:00	\$14,595.00	\$284,885.00	\$638,020.50				(701) 451-4864
405-10375	Equipment									DEPARTMENT APPROVAL
	Supplies		\$630.00	\$35.00	\$665.00	\$1,260.00				Program Director
	Training									By:
	Other (List Separately)									
	Contractual Services		\$7,220.00	\$355.00	\$7,575.00	\$19,692.00				Date:
	Advertising		\$23,664.00		\$23,664.00	\$61,500.00				Division Director
Ontine Delication	Administration/Indirect Costs	iii	\$5,730.00	\$329.00	\$6,059.00	\$11,659.50				By:
	Sub-Total		\$364,882.00	\$18,606.00	\$383,488.00					Alle June # Ox
Billing Period:	Less Advances/Program Income	Income (	<u>`</u>	( )	( )					Date: 7/7/17NIR
From: 1/1/2018 To: 1/31/2018	Totals	40	\$364,882.00	,	\$383,488.00	\$850,000.00				Program Accountant
DHS FINANCE USE ONLY:	Total Amount Requested for ReImbursement: (This billing period)	d for Reimburs (This	ement: billing period)	\$18,606.00		Drogram Income	Received To Date	Expended To Date	Remaining Balance	S.
REF Accounting LINE Period Date	Speed Dept. Chart ID	Account	Class	Fund	Project /	Activity Resource	Resource Category	TRAN	TRANSACTION	Date:
**************************************				,						

ECONOMIC ACCIOTANCE





Period Date Chart ID	REF Accounting Speed Dept. Account	DHS FINANCE USE ONLY: (This billing period)	Floin. 12/1/2017 10: 12/31/2017  Total Amount Requested for Reimbur	1	From: 7/1/2017 10: 6/30/2019 Less Advances/Program Income (		Administration/Indirect Costs	Advertising	Contractual Services	Other (List Separately)	Training		405-10375 Equipment	DHS Contract Number: Consultation Services	Travel	Salaries & Fringe Benefit Employees Only)	Expenditure Classification	to Abortion		-	Description of Service:	CONTRACT INFORMATION	(See reverse for instructions on completing this form).	SFN 1763 (Rev. 2-2017)	NORTH DARCTA DEPARTMENT OF HUMAN SERVICES	
	Class	his billing period)	sement:	\$342 703 00		\$342,703.00	\$5,401.00	\$23,664.00	\$6,807.00			\$595.00		\$252,180.00		\$54,056.00		Claimed	Expenditures	Total		Column A			האעוכהט	ECT SERVIC
	Fund	\$22,179.00			(	\$22,179.00	\$329.00		\$413.00			\$35.00		\$18,110.00		\$3,292.00		Period	Claimed	Expenditures		Column B				
5	ğ		000.,000.	\$364 882 00	(	\$364,882.00	\$5,730.00	\$23,664.00	\$7,220.00			\$630.00		\$270,290.00		\$57,348.00		Columns A & B	Expenditures	Cumulative		Column C	City: Fargo	Line 2:	Address Line 1: PO Box 9859	Vendor/ Provider Name:
lb lype	Activity Resource	Program Income	늗	- \$850,000,00	ت	,	\$11,659.50	\$61,500.00	\$19,692.00			\$1,260.00		\$638,020.50	\$1,275.00	\$116,593.00		Amendments)	Contract Award	Total		Column D		ı		/endor/ Provider Name: The Village Family Service Center
	ce Resource	Ų.	Received To Date														Reported	Previously	Allowable)	(Including	Expenditures	Column E				
			Expended To Date														renod	This Billing	Allowable)	(Including	Expenditures	Column F	State: ND			
AMOUNT	TRANSACTION		Remaining Balance														Columns E & F	to Date	In-Kind, if	Expenditures (Including	Matching	Column G Cumulative	Zip Code: 58106			
	Date:		by:	Program Accountant	Dale.		⊥ By:	Division Director	10/2010	IN TOTAL STATE OF THE STATE OF		Program Director	DEPARTMENT APPROVAL	(701) 451-4864	Payee Telephone Number:	1-10-18	Date	Imper bless	Payee Signature:	x No Yes	Is this the final reimbursement request	that such compliance is documented for audit purposes.	Department of Human Services, that matching fund requirements have been complied with and	vendonbrovider organization or	reflects expenditures for services rendered in accordance with an agreement between the	PAYEE CERTIFICATION  I hereby certify that this request accurately

### DEC 27 2017



to Abortion Description of Service: Alternatives (See reverse for instructions on completing this form) CONTRACT INFORMATION ECONOMIC ASSISTANCE
REQUEST FOR REIMBURSEMENT- DIRECT SERVICE FISCAL ADMINISTRATION SFN 1763 (Rev. 2-2017) NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES Salaries & Fringe Benefit (Employees Expenditure Classification Expenditures Previously Column A \$50,764.00 Claimed Expenditures This Billing Column B Period Claimed \$3,292.00 City: Fargo Address Line 1: PO Box 9859 Vendor/ Provider Name: Columns A & B The Village Family Service Center Expenditures Cumulative Column C \$54,056.00 To Date Line 2: Contract Award Amendments) (Including all \$116,593.00 Column'D \$1,275.00 Total **Total Matching** Expenditures (Including In-Kind, if Previously Allowable) Column E Reported State: Expenditures (Including In-Kind, if This Billing Allowable) Matching Column F Period 20 Zip Code: 58106 Columns E & F Column G Cumulative (Including In-Kind, if Allowable) Expenditures Matching to Date Department of Human Services, that matching fund requirements have been complied with and Date: that such compliance is documented for audit Payee Telephone Number: Payee Signature: for this contract? (Please check a box) purposes. vendor/provider organization or agency identified above and the North Dakota accordance with an agreement between the reflects expenditures for services rendered in I hereby certify that this request accurately × S PAYEE CERTIFICATION 2-12-Yes

			REF Accounting LINE Period Date	DHS FINANCE USE ONLY:		From: 11/1/2017 To: 11/30/2017	Billing Period:	From: 7/1/2017 To: 6/30/2019	Contract Period:							405-10375	DHS Contract Number:
			Speed D.	(This billing period)	Total Amount R	Totals	Fe33 Vavallesa, 108 an illeans	l acc Advances	Sub-Total	Administration/Indirect Costs	Advertising	Contractual Services	Other (List Separately)	Training	Supplies	Equipment	Consultation Services
-			Dept. Ac		equested fo		10gratii IIIc	Program Inc		rect Costs		vices	ely)				es
			Account	(This	r Reimburs	€0	70,170	ome /									€9
			Class	s billing period)	ement:	\$322,464.00		_	\$322,464.00	\$5,072.00	\$23,664.00	\$6,394.00			\$560.00		\$236,010.00
			Fund	\$20,239.00					\$20,239.00	\$329.00	\$0.00	\$413.00			\$35.00		\$16,170.00
			Project ID	And the second control of the second control		\$342,703.00	(	7	\$342,703.00	\$5,401.00	\$23,664.00	\$6,807.00			\$595.00		\$252,180.00
	-		Activity ID	Progra		H	L								\$1		\$638
			Resource Type	Program Income	Re	\$850,000.00				\$11,659.50	\$61,500.00	\$19,692.00			\$1,260.00	<u></u>	\$638,020.50
			Resource Category		Received To Date E												
			TRAN AN		Expended To Date												
			TRANSACTION AMOUNT		Remaining Balance												
	1		Date:		<b>1</b>	By:		Date:		By:	Division Director	Date: 17]77 7010	71 ( H mmm) 11		Program Director	DEPARTMENT APPROVAL	(701) 451-4864

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ECOMONARY ASSERTATIONS

(	TO TO THE WIND TO THE	MENT- D	RECT SERV	2	Vendor/ Provider Name:	Name.				
FISCAL ADA	NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES FISCAL ADMINISTRATION	F HUMAN	SERVICES		The Village Fa	The Village Family Service Center	ter			I hereby certify that this request accurately
	v. 2-2017)				Address Line 1: PO Box 9859	PO Box 9859				reflects expenditures for services rendered in
(See reverse for instructions on completing this form)	romalating this form)				Line 2:					vendor/provider organization or agency
	completing this form).				City:			State:	Zip Code:	identified above and the North Dakota
CONTRACT INFORMATION					Fargo		Column	No	58106	fund requirements have been complied with and
Description of Service:	<b></b>	• • • • • • • • • • • • • • • • • • • •	Column A	Column B	Column C	Column D	Total Matching	Matching	Column G Cumulative	that such compliance is documented for audit purposes.
			Total	1			Expenditures	Expenditures	Matching	Is this the final reimbursement request
Alternatives			Expenditures	Claimed	Expenditures	Total Contract Award	In-Kind, if	In-Kind, if	(Including	X No Yes
2000101			Previously	This Billing	To Date	(Including all	Allowable)	Allowable)	in-Kind, if Allowable)	Payée Signature:
	Expenditure Classification	tion		- ci	· ·	Amendments)	Reported	Period	to Date	Comper Kusten
	Only)	the state of the s	\$47,472.00	\$3,292.00	\$50,764.00	\$116,593.00				Date: //- }-/7
	Travel					\$1,275.00				Payee Telephone Number:
DHS Contract Number:	Consultation Services		\$216,345.00	\$19,665.00	\$236,010.00	\$638,020.50				(701) 451-4864
405-103/5	Equipment									DEPARTMENT APPROVAL
	Supplies		\$525.00	\$35.00	\$560.00	\$1,260.00				Program Director
	Training									By:
	Other (List Separately)									
	Contractual Services		\$5,981.00	\$413.00	\$6,394.00	\$19,692.00				Date:
	Advertising		\$23,664.00		\$23,664.00	\$61,500.00				72.1.
Contract Deriod:	Administration/Indirect Costs	ß	\$4,743.00	\$329.00	\$5,072.00	\$11,659.50				By
From: 7/1/2017 To: 6/30/2019	Sub-Total		\$298,730.00	\$23,734.00	\$322,464.00		•			
	Less Advances/Program Income	Income (		(	( )					Date: 11 1 7 1 7
From: 10/1/2017 To: 10/31/2017	Totals		\$298,730.00		\$322,464.00	\$850,000.00				Program Accountant
DHS FINANCE USE ONLY:	iotal Amount Requested for Reimbursement; (This billing period)	i for Reimbu (Ti		\$23,734.00		Program Income	Received To Date	Expended To Date	Remaining Balance	9.
REF Accounting	Speed Dept.	Account	Class	Find		Activity Resource			CACTION	
LINE Penod Date	-	2000	Ciaso	7 110	5		Category		AMOUNT	Date:
										ŧ



REF Accounting S	DHS FINANCE USE ONLY:	From: 9/1/2017 To: 9/30/2017				Ъ	10	0		S	405-10375	DHS Contract Number:	1=1	<u>ο</u> ω		Abortion	Alternatives to	Description of Service:	CONTRACT INFORMATION	(see reverse for instructions on completing this form).		FISCAL ADMINISTRATION SFN 1763 (Rev. 2-2017)	REQUEST FOR NORTH DAKO
Speed Dept. Account	iotal Amount Requested for Reimbursement: (This billing period)	Totals	Less Advances/Program Income	Sub-Total	Administration/Indirect Costs	Advertising	Contractual Services	Other (List Separately)	Training	Supplies	Equipment	Consultation Services	Travel	Salaries & Fringe Benefit (Employees Only)	Expenditure Classification					ompleting this form).		USTRATION	REQUEST FOR REIMBURSEMENT- DIRECT SERVICE NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
Class	(This billing period)	\$276,046.00	( )	\$276,046.00	\$4,414.00	\$23,664.00	\$5,568.00			\$490.00		\$197,730.00		\$44,180.00	Callied	Previously	Expenditures	<u> </u>	Column A				DIRECT SERV
Fund	\$22,684.00		( )	\$22,684.00	\$329.00		\$413.00			\$35.00		\$18,615.00		\$3,292.00	renou	This Billing	Claimed	1	Column B				ICE
Project Ac		\$298,730.00	(	\$298,730.00	\$4,743.00	\$23,664.00	\$5,981.00			\$525.00		\$216,345.00		\$47,472.00	Columns A & B	To Date	Expenditures		Column C	City: Fargo	Line 2:	Address Line 1: PO Box 9859	Vendor/ Provider Name: The Village Family Se
Activity Resource ID Type	Program Income	\$850,000.00			\$11,659.50	\$61,500.00	\$19,692.00			\$1,260.00		\$638,020.50	\$1,275.00	\$116,593.00	Amenaments)	(Including all	Total Contract Award		Column D			O Box 9859	vendor/ Provider Name: The Village Family Service Center
ce Resource Category	Necessary of Care	Book & Date													Reported	Previously	In-Kind, if	Expenditures	Column E Total Matching				¥
	Lybenness to Cate	Supposed to Date													Period	This Billing	In-Kind, if	Expenditures	Column F Matching	State: ND			
TRANSACTION AMOUNT	Nothighned Calabon														to Date Columns E & F	Allowable)	(Including	Matching Expenditures	Column G Cumulative	Zip Code: 58106			
Date:		By:	Date: 10-14-1017	Suck	By:	Division Director	Date:		Ç	Program Director	DEPARTMENT APPROVAL	(701) 451-4864	Payee Telephone Number:	Date: 10-11-17	Three blakey	rayee signature:	No Yes	Is this the final reimbursement request for this contract? (Please check a box)	that such compliance is documented for audit purposes.	Department of Human Services, that matching fund requirements have been complied with and	vendor/provider organization or agency	reflects expenditures for services rendered in accordance with an agreement hetween the	PAYEE CERTIFICATION I hereby certify that this request accurately





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NORTH DAK	NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES	TUMAN SERVICES	VICE VICE	The Village Family Se	The Village Family Service Center	7			PAYEE CERTIFICATION
100	FISCAL ADMINISTRATION			Address Line 1: PO Box 9859	O Box 9859				reflects expenditures for services rendered in
O 100 (100 (100 272011)	. 5-20 (1)	. •		Line 2:					vendor/provider organization or agency
See reverse for instructions on completing this form).	completing this form).			City: Fargo			State: ND	Zip Code: 58106	identified above and the North Dakota Department of Human Services, that matching find requirements have been considerable and
CONTRACT INFORMATION Description of Service:	•	Column A	Column B	Column C	Column D	Column E Total Matching Expenditures	Column F Matching	Column G Cumulative Matching	that such compliance is documented for audit purposes.
	,	Total	Expenditures	Cumulative	Total	(Including	(Including	Expenditures	ntract? (P
Alternatives to		Expenditures Previously	Claimed This Billing	Expenditures To Date	Contract Award	In-Kind, if Allowable)	In-Kind, if Allowable)	In-Kind, if	Payée Signéture: //
Abortion	Expenditure Classification		Period	Columns A & B	Amendments)	Previously Reported	This Billing Period	to Date	Emper Hudy
	Salaries & Fringe Benefit (Employees Only)	\$40,888.00	\$3,292.00	\$44,180.00	\$116,593.00				Date: 9-8-17
	Travel				\$1,275.00				Payee Telephone Number:
DHS Contract Number:	Consultation Services	\$179,090.00	\$18,640.00	\$197,730.00	\$638,020.50				(701) 451-4864
105-10375	Equipment								DEPARTMENT APPROVAL
	Supplies	\$455.00	\$35.00	\$490.00	\$1,260.00				Program Director
	Training								Ö
	Other (List Separately)								
	Contractual Services	\$5,155.00	\$413.00	\$5,568.00	\$19,692.00				Date:
	Advertising	\$23,664.00		\$23,664.00	\$61,500.00				Division Director
	Administration/Indirect Costs	\$4,085.00	\$329.00	\$4,414.00	\$11,659.50				By:
_	Sub-Total	\$253,337.00	\$22,709.00	\$276,046.00					Carol Cartloto
Billing Perlod:	Less Advances/Program Income	come (	) (	)					Date: 9-11-3019
rom: 8/1/2017 To: 8/31/2017	Totals	\$253,337.00		\$276,046.00	\$850,000.00				Program Accountant By:
	Total Amount Requested for Reimbursement:	or Reimbursement:	_			Received To Date	Expended To Date	Remaining Balance	
ΖŽ		( i his billing period)	\$22,709.00		Program income				
LINE Period Date	Speed Dept. /	Account Class	Fund	Project Ac	Activity Resource	e Resource Category		TRANSACTION AMOUNT	Date:
_	-	_	-	_		_	_		





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NORTH DAN	NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES	AN SERVICES	/ICE	The Village Family Se	Name:				PAYEE CERTIFICATION
	FISCAL ADMINISTRATION SFN 1763 (Rev. 2-2017)	ָרָ . היי		Address Line 1:	Address Line 1: PO Box 9859				I hereby certify that this request accurate reflects expenditures for services rendered
(See reverse for instructions on completing this form)	completing this form			Line 2:					accordance with an agreement between th vendor/provider organization or agence
	completing and form).			City: Fargo			State:	Zip Code:	dentified above and the North Dakot Department of Human Services, that matchin
CONTRACT INFORMATION  Description of Service:		Column A	Column B	Column C	Column D	Column E Total Matching	Column F Matching	Column G Cumulative	und requirements have been complied with an that such compliance is documented for aud purposes.
Alternatives to	٠	Total Expenditures	Expenditures Claimed	Cumulative	Total Contract Award	(Including In-Kind, if	(Including	Expenditures (Including	for this contract? (Please check a box)  x No  yes
Abdition		Previously	This Billing	To Date	(Including all	Allowable)	Allowable)	Allowable)	Payed Signature: //
	Expenditure Classification	Claimed	Period	Columns A & B	Amendments)	Reported	Period	to Date	I I work their
	Salaries & Fringe Benefit (Employees Only)		\$3,292.00	\$3,292.00	\$78,997.00			Committee	Date: 8,4-17
	Travel								Payee Telephone Number:
DHS Contract Number:	Consultation Services		\$15,405.00	\$15,405.00	\$491,055.00		-		(701) 451-4864
405-10375	Equipment								DEPARTMENT APPROVAL
	Supplies		\$35.00	\$35.00	\$840.00				Program Director
	Training								By:
	Other (List Separately)								
	Contractual Services		\$413.00	\$413.00	\$9,708.00				Date:
	Advertising				\$11,500.00				
Contract Pariod:	Administration/Indirect Costs		\$329.00	\$329.00	\$7,900.00				By:
From: 7/1/2017 To: 6/30/2019	Sub-Total		\$19,474.00	\$19,474.00					Carol Carlodin
- 1	Less Advances/Program Income	( )	( )	( )					Date: 8-14.3517
From: 7/1/2017 To: 7/31/2017	Totals			\$19,474.00	\$600,000.00				Program Accountant
DHS FINANCE USE ONLY:	Total Amount Requested for Reimbursement: (This billing period)	nbursement: (This billing period)	\$19,474.00		Program Income	Received To Date	Expended To Date	Remaining Balance	
REF Accounting LINE Period Date	Speed Dept Account Chart ID Account	nt Class	Fund	Project Ac	Activity Resource	Resource Category		TRANSACTION	Date:
					•				





TOF HUMAN SERVICES   Address Line 1: PO Box 9859   Address Line 2:   Address Line 1: PO Box 9859   Address Line 2:   Address Line 2:   Address Line 2:   Address Line 2:   Address Line 3:   A	\$211,372.00   \$233,863.00   steel for Reimbursement (This billing period)   \$22,491.00
TOF HUMAN SERVICES	Advances/Program income ( ) ( ) (
TOF HUMAN SERVICES   Address to PO Box 9859   Line 2:   State:   ND   58196   Column C   Column B   Column B   Column C   Column B   Column C   Column B   Column B   Column B   Column C   Column B   Column C   Column B	Advances/Program income ( ) ( ) (
TOF HUMAN SERVICES   Address Line 1; PO Box 9859   Line 2;   State: ND   58196   Column C   Column B   Column C   Column B   Column C   Column B   Column B   Column C   Column B   Column C   Column D   Total Matching   Column B   Column B   Column B   Column C   Column D   Total Matching   Column B   Colu	Less Advances/Program Income ( ) ( ) ( )
TOF HUMAN SERVICES   Address Line 1: pO Box 9859   Sale: National Service Center   Address Line 2:   Ciliv:   Ciliv:   Ciliv:   Ciliv:   Ciliv:   Column B   Column B   Column C   Column B   Column B   Column B   Column B   Column Date   Column B   Column B   Column C   Column Date   Column B   Expenditures   Column B   Expenditures   Column B   Expenditures   Column B   Expenditures   Column B   Expenditures   Column B   Column B   Expenditures   Column	
TOF HUMAN SERVICES	\$22,491.00
TOF HUMAN SERVICES	\$313.00
TOF HUMAN SERVICES	. \$2,000.00
TOF HUMAN SERVICES	\$449.00
TOF HUMAN SERVICES	Other (List Separately)
TOF HUMAN SERVICES	Training
TOF HUMAN SERVICES	\$35.00
TOF HUMAN SERVICES	Equipment
TOF HUMAN SERVICES  The Village Family Service Center  Address Line 1: PO Box 9859  Line 2:  City:  City:  Column C  Column D  Column E  Column B  Column B  Column C  Column D  Column E  Column D  Column E  Column G  Column B  In-Kind, if In-Kind	\$16,561.00
TOF HUMAN SERVICES  The Village Family Service Center  Address Line 1: PO Box 9859  Line 2:  City:  City:  Column C  Column B  Column C  Column D  Column E  Column D  Column E  Column E  Column D  Column E  Column G  Column E  Column G  Column B  Altowable)  Altowab	Travel
TOF HUMAN SERVICES  The Village Family Service Center  Line 2:  City:  City:  Column B  Column C  Column B  Column C  Column B  Column C  Column C  Column B  Column C  Column E  Column G  Column G  Column C  Column C  Column C  Column C  Column E  Column E  Column E  Column G  Column G	\$3,133.00
TOF HUMAN SERVICES  The Village Family Service Center  Address Line 1: PO Box 9859  Line 2:  City:  City:  Column A  Column B  Column C  Column B  Column C  Column D  Column B  Column C  Column D  Column B  Column C  Column D  Column C  Column C  Column E  Column E  Column C  Column E  Column E  Column G	Claimed Period
TOF HUMAN SERVICES  The Village Family Service Center  Address Line 1: PO Box 9859  Line 2:  City:  City:  Column A  Column B  Column C  Column B  Column C  Column B  Column C  Column C  Column C  Column C  Column E  Column E  Column C	Claimed
The Village Family Service Center	
T OF HUMAN SERVICES  The Village Family Service Center  Address Line 1: PO Box 9859  Line 2:  City:  Fargo  State:  ND  58106	Column B
T OF HUMAN SERVICES  The Village Family Service Center  Address Line 1: PO Box 9859  Line 2:	Fargo
The Village Family Service Center Address Line 1: PO Box 9859	25
The Village Family Service Center	·/
BURSEMENT- DIRECT SERVICE   Vendorl Provider Name: PAYEE CERTIFICATION	REQUEST FOR REIMBURSEMENT- DIRECT SERVICE  Vendor! Provider N  NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  The Village Fami
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	REQUEST FOR REIMBURSEMENT- DIRECT SERVICE	RECT SERVI		The Village Family Se	The Village Family Service Center	<b>,</b>			hereby certify that this request accurately
NORTH DAKOTA DEPART	NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES	טהאטוכהט	<u> </u>	Address Line 1: PO Box 9859	O Box 9859				reflects expenditures for services rendered in accordance with an agreement between the
110	2-2017)		<del></del>	Line 2:					vendorprovider organization or agency
See reverse for instructions on completing this form).	ompleting this form).			City:			State:	Zip Code:	Department of Human Services, that matching
			_	2 de la companya de l	2	Column E	٦	ัด	that such compliance is documented for audit
		Colonia		O C	1	Expenditures	Expenditures	Matching	Is this the final reimbursement request
escription of Service:			!	}	7	(Including	(Including	Expenditures	for this contract? (Please check a box)
		Total	Expenditures	Cumulative	Contract Award	In-Kind, if	In-Kind, if	(including	JL
Alternatives		Expenditures Praviously	Claimed This Billing	Expenditures To Date	(Including all	Allowable)	Allowable)	Allowable)	Payee Signature:
0 000000	Tunandit no Classification	C:aimed		Columns A & B	Amendments)	Reported	Period	to Date	amper studen
	Salaries & Fringe Benefit (Employees	\$28.197.00	\$3,133,00	\$31,330.00	\$37,596.00				5-10-17
	Travel ·				\$1,275.00				Payee Telephone Number:
DHS Contract Number:	Consultation Services	\$122,080.00	\$10,272.00	\$132,352.00	\$146,965.50				(701) 451-4864
405-10375	Folimment			•					DEPARTMENT APPROVAL
	Supplies	\$315.00	\$35.00	\$350.00	\$420.00				By:
	Training								
	Other (List Separately)								
	Contractual Services	\$3,512.00	\$449.00	\$3,961.00	\$9,984.00		·		Cale:
	Advertising	\$13,664.00	\$4,000.00	\$17,664.00	\$50,000.00				Division Director
	Administration/Indirect Costs	\$2,817.00	\$313.00	\$3,130.00	\$3,759.50				S. S
Contract Period:	Sub-Total	\$170,585.00	\$18,202.00	\$188,787.00					5
From: 7/1/2016 To: 6/30/2017	Top Advances/Brogram Income		7						10401
Billing Period:	The state of the s								Program Accountant
From: 4/1/2017 To: 4/30/2017	Totals	\$170,585.00		\$188,787.00	\$250,000.00	Ē			By:
	Total Amount Requested for Relm	bursement:	_		1.	Received To Date	Expended to Date	Kemahing balanca	
DHS FINANCE USE ONLY:	(This billing period)	(This billing period)	\$18,202.00		rami			NSACTION	Date
REF Accounting LINE Period Date	Speed Dept Account Chart ID Account	Class	Fund	Project ID	ID Type	e Category		AMOUNT	Daig
									. 1.
	_	_	_			-			

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Abortion Alternatives to

Salaries & Fringe Benefit (Employees Expenditure Classification

\$25,064.00

\$3,133.00

\$28,197.00

\$37,596.00

Expenditures Previously

Claimed

Expenditures

Contract Award Amendments) (Including all

Allowable) Previously

Allowable)
This Billing In-Kind, if

Reported

Period

Columns E & F

4-12-17

to Date

Payled Signature:

To Date

Claimed

This Billing Period

Columns A & B

ENORTH DAKOTA DEPARTMENT OF HUMAN SERVICES FISCAL MEMMINISTRATION ANCE
SFN 1763 (Rev. 2-2017) REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

Description of Service: (See reverse for instructions on completing this form) CONTRACT INFORMATION Column A Total Expenditures Column B City: Address Line 1: PO Box 9859 The Village Family Service Center Vendor/ Provider Name: Cumulative Column C Line 2: Column D Total **Total Matching** Expenditures (Including In-Kind, if Column E State: Matching Expenditures (Including Column F B Zip Code: 58106 Expenditures (Including In-Kind, if Allowable) Cumulative Matching Column G identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the vendon/phovider organization or agency identified above and the North Dakota Is this the final reimbursement request for this contract? (Please check a box) purposes. that such compliance is documented for audit × No PAYEE CERTIFICATION Yes

								_	_	_			
	AMOUNT		Category	Туре	ō	8				5	Chart	renod Date	LINE
Date:	TRANSACTION	TRA	Resource	Resource	Activity	Project	Fund	Class	Account	Dept	Speed	Accounting	REF
				Program Income	Program		\$24,563.00	(This billing penod)			: 	DHS FINANCE USE ONLY:	DHS FIN
	Remaining Balance	Expended To Date	Received To Date E	Rece				irsement:	Total Amount Requested for Reimbursement:	mount Reque	Total Ar		
Program Accountant				\$250,000.00	Н	\$170,585.00		\$146,022.00			17 Totals	From: 3/1/2017 To: 3/31/2017	From: 3/
4-17-7017 0	·				تا	(	)	(	am Income	Less Advances/Program Income	Less Adv	riod:	Billing Period:
Date:					ا <b>ل</b>				-	,	4	1/2016 10: 6/30/2017	From: 7/1/2016
Can of Cartind in					ō	\$170,585.00	\$24,563.00	\$146,022.00			Sub-Total	i i	1 (
•												Period:	Contract Period
By:				\$3,759.50		\$2,817.00	\$313.00	\$2,504.00	Costs	Administration/Indirect Costs	Administra		
Division Director				\$50,000.00		\$13,664.00	\$4,000.00	\$9,664.00		ing .	Advertising		
Date:				\$9,984.00	<del>                                     </del>	\$3,512.00	\$390.00	\$3,122.00	S	Contractual Services	Contract		
										Other (List Separately)	Other (List		
σ <u>.</u>								:			Training		, -
Program Director				\$420.00		\$315.00	\$35.00	\$280.00			Supplies		
DEPARTMENT APPROVAL						=					Equipment	75	405-10375
(701) 451-4864				\$146,965.50	]	\$122,080.00	\$16,692.00	\$105,388.00		Consultation Services	Consultatio	DHS Contract Number:	DHS Con
rayee Telephone Number:				\$1,275.00	\$1						Travel		

TO MINON APR 1 7 2017







ALAN STATE OF THE PARTY OF THE									
	REQUEST FOR REIMBURSEMENT- DIRECT SERVICE	- DIRECT SERV	ICE	Vendor/ Provider Name:	Vendor/ Provider Name:	ξ.			PAYEE CERTIFICATION
FISCAL ADM	FISCAL ADMINISTRATION	AN OFRVICES		Address Line 1: PO Box 9859	PO Box 9859				reflects expenditures for services rendered in
SFN 1763 (Rev. 2-2017)	v. 2-2017)			Line 2:					vider organization or
(See reverse for instructions on completing this form).	n completing this form).	··.		City: Fargo			State: ND	Zip Code: 58106	Identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and
CONTRACT INFORMATION		Column A	Column B	Column C	Column D	Column E	Column F	Column G Cumulative	that such compliance is documented for audit purposes.
Description of Service:						Expenditures	Expenditures	Matching	Is this the final reimbursement request for this contract? (Please check a box)
		Total	Expenditures	Cumulative	Total	In-Kind, if	In-Kind, if	(Including	X No Yes
Alternatives to		Previously	This Billing	To Date	(Including all	Allowable)	Allowable)	In-Kind, if Allowable)	Payee \$ignature: //
Abortion	Expenditure Classification	Claimed	Period	Columns A & B	Amendments)	Reported	Period	to Date	Camper Weekley
	Salaries & Fringe Benefit (Employees Only)	\$21,931.00	\$3,133.00	\$25,064.00	\$37,596.00				3-9-17
	Travel				\$1,275.00				Payee Telephone Number:
DHS Contract Number:	Consultation Services	\$95,528.00	\$9,860.00	\$105,388.00	\$146,965.50				(701) 451-4864
405-10375	Equipment								DEPARTMENT APPROVAL
	Supplies	\$245.00	\$35.00	\$280.00	\$420.00				Program Director
	Training								
	Other (List Separately)								
	Contractual Services	\$2,732.00	\$390.00	\$3,122.00	\$9,984.00				Date:
	Advertising	\$5,579.00	\$4,085.00	\$9,664.00	\$50,000.00				Division Director
	Administration/Indirect Costs	\$2,191.00	\$313.00	\$2,504.00	\$3,759.50				By
	Sub-Total	\$128,206.00	\$17,816.00	\$146,022.00	L				Canol Cantlos
Billing Period:	Less Advances/Program Income	e ( )	(	( )					Date: 3-10-2017 0
From: 2/1/2017 To: 2/28/2017	Totals	\$128,206.00		\$146,022.00	\$250,000.00				By:
DHO BINANOB LIOE ONI V	Total Amount Requested for Reimbursement: (This billing period)	imbursement: (This billing period)	\$17,816.00		Program Income	Received To Date	Expended To Date	Remaining Balance	
REF Accounting Period Date	Speed Dept Account	unt Class	Fund	Project ID	Activity Resource	rce Resource Category		TRANSACTION	Date:
200									

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FISCAL ADMINISTE SEN 1763 (Rev. 2-2017)	NORTH DAKOTA DEPARTMENT OF HOMAN BERVICES FISCAL ADMINISTRATION SEN 1763 (Rev 2.2017)	SERVICES	i	The Village Family Service ( Address Line 1: PO Box 9859	The Village Family Service Centel Address Line 1: PO Box 9859	5[			I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the
OF N 1700 (No	v. 2-2011)			Line 2:					
(See reverse for instructions on completing this form).	n completing this form).			City: Fargo			State: ND	Zip Code: 58106	identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and
CONTRACT INFORMATION		Column A	Column B	Column C	Column D	Column E		Column G	that such compliance is documented for audit purposes
Description of Service:						Expenditures	Expenditures	Matching	Is this the final reimbursement request
		Total	Expenditures Claimed	Cumulative	Total Contract Award	(Including In-Kind, if	(Including In-Kind, if	Expenditures (Including	for this contract? (Please check a box)  X No Yes
Alternatives to		Previously	This Billing	To Date	(Including all	Allowable)	Allowable)	Alfowable)	Payee/Signature:
Abortion	Expenditure Classification	Claimed	Period	Columns A & B	Amendments)	Reported	Period	to Date	18mber Heden
	Salaries & Fringe Benefit (Employees Only)	\$18,798.00	\$3,133.00	\$21.931.00	\$37.596.00			- C	Date: 7-1/2
	Travel				\$1,275.00				Payee Telephone Number:
DHS Contract Number:	Consultation Services	\$85,132.00	\$10,396.00	\$95,528.00	\$146,965.50				(701) 451-4864
405-10375	Equipment								DEPARTMENT APPROVAL
	Supplies	\$210.00	\$35.00	\$245.00	\$420.00				Program Director
	Training								sy:
	Other (List Separately)								Carco Cartodo
	Contractual Services	\$2,342.00	\$390.00	\$2,732.00	\$9,984.00				J. (
	Advertising		\$5,579.00	\$5,579.00	\$50,000.00				Division Director
	Administration/Indirect Costs	\$1,878.00	\$313.00	\$2,191.00	\$3,759.50		•		By:
• •	Sub-Total	\$108,360.00	\$19,846.00	\$128,206.00					
Billing Period:	Less Advances/Program Income	e ( )	^ 	<u>^</u>					Date:
From: 1/1/2017 To: 1/31/2017	Totals	\$108,360.00		\$128,206.00	\$250,000.00				Program Accountant
	Total Amount Requested for Reimbursement:	imbursement:				Received To Date	Expended To Date	Remaining Balance	Dy.
DHS FINANCE USE ONLY:		(This billing period)	\$19,846.00		Program Income				
REF Accounting LINE Period Date	Speed Dept. Account	ınt Class	Fund	Project A	Activity Resource	ce Resource Category		TRANSACTION	Date:
								CON	
							_		







with check													
Canary - returned to wender/provider									-				
White/Canary - Finance													
DISTRIBUTION:													
<u> </u>	AMOUNT	A	Category		L	ō	rung	Cidss	Account	ō	Chart	E Period Date	LINE
	TRANSACTION	TRAI	$\frac{1}{1}$	v Resource	Ac	Project			2	Dept.	- 1	Accounting	REF
				Program Income	Pro	<u></u>	\$16,791.00	(This billing period)				DHS FINANCE USE ONLY:	DHS
o y	Remaining Balance	Expended To Date	Received To Date			ا 		Total Amount Requested for Reimbursement:	sted for Reimt	mount Reque	Total A		
Liaison Accountant				\$250,000.00	\$108,360.00	\$108,		\$91,569.00			16 Totals	From: 12/1/2016 To: 12/31/2016	From:
1-19-2017 U					_	<u>~</u>		( )	am income	Less Advances/Program Income	Less Ad	Billing Period:	Billing
,						`	,	,		j	Ļ	From: 7/1/2016 To: 6/30/2017	From:
1 C CY17 (C)1+(C)					360.00	0 \$108,360.00	\$16,791.00	\$91,569.00		=	Sub-Tota	-	1 (
By:				\$3,759.50	\$1,878.00	<u> </u>	\$313.00	\$1,565.00	Costs	Administration/Indirect Costs	Administr		
Division Director				\$50,000.00						ing	Advertising		<del></del>
Date:				\$9,984.00	\$2,342.00		\$390.00	\$1,952.00	Š	Contractual Services	Contrac		
										Other (List Separately)	Other (Lis		•
o X											Training		
Program Director		-		\$420.00	\$210.00		\$35.00	\$175.00			Supplies		
DEPARTMENT APPROVAL					İ					nt .	Equipment	0375	405-10375
(701) 451-4864				\$146,965.50	\$85,132.00		\$12,920.00	\$72,212.00		Consultation Services	Consultati	DHS Contract Number:	DHS
Payee Telephone Number:				\$1,275.00							Travel		
1-16-17 1				\$37,596.00	\$18,798.00		\$3,133.00	\$15,665.00	L (Employees	Only)	Only)		
Jampe Harling	to Date Columns E & F	Period	Reported	Amendments)		Columns A &	Period	Claimed	cation	Expenditure Classification	Expen		
Payee Signature: //	Allowable)	Allowable)	Allowable)	(Including all		To Date	This Billing	Previously				ion	Abortion
X No Yes	(Including	Including In-Kind, if	Including	Total Contract Award		s Cumulative Expenditures	Expenditures Claimed	Total Expenditures				Alternatives to	Altern
Is this the final reimbursement request	Matching	Expenditures	Expenditures									Description of Service:	Descri
that such compliance is documented for audit purposes.	Column G	Column F	Column E	Column D	nn C	Column C	Column B	Column A			Ž	CONTRACT INFORMATION	CON
Department of Human Services, that matching fund requirements have been complied with and	Zip Code: 58106	State: ND				City: Fargo				g this form).	on completin	(See Tevelse to Historicalist on Completing this form)	(000
vendor/provider organization or agency					Line 2:								6
reflects expenditures for services rendered in accordance with an agreement hetween the				30x 9859	Address Line 1: PO Box 9859	Address					SFN 1763 (Rev. 09-2005)	110	(S)
hereby certify that this request accurately				The Village Family Service Center	age Family	The Vill	ī	ND DEPARTMENTOF HUMAN SERVICES	ERVICES	HUMAN SI	RIMENTOF	ND DEPA	6
	A			Đ.	Vendor/ Provider Name:	Vendor/		NBECT SED	EMENT I	FIMBLIRS	ST FOR R	2/1	112

Pink - retained by vendor/provider





ŋ	FOR REIMBURSEN	ENT- DIF	RECT SERVI	CE	Vendor/ Provider Name:	Name: **: ;				PAYEE CERTIFICATION
FISCAL ADM	NO DEFENT IMENIOF FIORING SERVICES SEN 1763 (DW. 06 2005)	CIO			Address Line 1: PO Box 9859	Address Line 1: PO Box 9859				reflects expenditures for services rendered in
OFN 1765 (Rev. 09-2005)	09-2003)				Line 2:					ovider organization or
See reverse for instructions on completing this form).	completing this form).				City: Fargo			State: ND	Zip Code: 58106	dentitled above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and
CONTRACT INFORMATION			Column A	Column B	Column C	Column D	Column E	Column F	Column G	that such compliance is documented for audit purposes.
Description of Service:							Expenditures	Expenditures	Matching	Is this the final reimbursement request
			Total	Expenditures	Cumulative	Total	(Including In-Kind, if	(Including In-Kind, if	(Including	X No Yes
Alternatives to			Previously	This Billing	Expenditures	(Including all	Allowable)	Allowable)	In-Kind, if	Payée Signature: //
Abortion	Expenditure Classification	3	Claimed	Period	Columns A & B	Amendments)	Previously Reported	This Billing Period	to Date	Compact delater
	Salaries & Fringe Benefit (Employees Only)	oloyees	\$12,532.00	\$3,133.00	\$15,665.00	\$37,596.00				Date: 12-13-16
	Travel					\$1,275.00				Payee Telephone Number:
DHS Contract Number:	Consultation Services		\$60,768.00	\$11,444.00	\$72,212.00	\$146,965.50				(701) 451-4864
405-10375	Equipment	`								DEPARTMENT APPROVAL
	Supplies		\$140.00	\$35.00	\$175.00	\$420.00			,	Program Director
	Training									
	Other (List Separately)									
	Contractual Services		\$1,562.00	\$390.00	\$1,952.00	\$9,984.00				Date:
	Advertising					\$50,000.00				Division Director
	Administration/Indirect Costs	is .	\$1,252.00	\$313.00	\$1,565.00	\$3,759.50				By:
	Sub-Total		\$76,254.00	\$15,315.00	\$91,569.00					Cand antedp
Billing Period:	Less Advances/Program Income	Income (	)	( )	( )	<b>1</b>				Date: 12-10-160
From: 11/1/2016 To: 11/30/2016	Totals		\$76,254.00		\$91,569.00	\$250,000.00				By:
	Total Amount Requested for Reimbursement: (This billing period)	for Reimbu	rsement: nis billing period)	\$15 315 00			Received To Date	Expended To Date	Remaining Balance	,
REF Accounting	Speed Dept.	Account	Class	Fund	Project	Activity Resource	ce Resource		TRANSACTION	Date:
									AMOON	
										DISTRIBUTION: - White/Canary - Finance
										Canary - returned to vendor/provider
										Dink retained by yendor/provider





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	LINE	DHS FINAN		From: 10/1/2016	Billing Period:	From: 7/1/2016	Contract Period:							405-10375	DHS Contract Number				Abortion	Altornativos t		Description of Service:	CONTRACTI	See reverse fo	(Sp.)	The state of the s		
	Accounting Period Date	DHS FINANCE USE ONLY		16 To: 10/31/2016	- 1	6 To: 6/30/2017	d:								Number:				C	,		Service:	CONTRACT INFORMATION	(See reverse for instructions on completing this form).		FISCAL ADMINISTR	ND DEPART	てつ ここれの
	Speed Chart	2		Totals	Less Advar		Sub-Total	Administratio	Advertising	Contractual Services	Other (List Separately)	Training	Supplies	Equipment	Consultation Services	Travel	Salaries & Fri	Expenditu						completing:th	,	MINISTRATIC	MENTOF HU	משם מכח
	10 Dept.		unt Requested		Less Advances/Program Income			Administration/Indirect Costs		Services	parately)			v41 <b>6</b> 11	Services		Salaries & Fringe Benefit (Employees Only)	Expenditure Classification						is form).		ž	MAN SERVI	MESOCION
	Account		for Reimbu		ncome			)									oyees	ň					·············				CES	ロハナーコ
	Class.		Total Amount Requested for Reimbursement: (This billing period)	\$57,027.00	,		\$57 007 00	\$939.00	\$0.00	\$1,172.00			\$105.00		\$45,412.00		\$9,399.00		Claimed	Expenditures	Total		Column A			. *	ND DEPARTMENTOF HUMAN SERVICES	DECT AERVI
	Fund		\$19,227.00				\$19 227.00	\$313.00		\$390.00			\$35.00		\$15,356.00		\$3,133.00		Period	Claimed	Expenditures		Column B				ſ	) II
	ID	1		\$76,254.00			\$76.254.00	\$1,252.00		\$1,562.00			\$140.00		\$60,768.00		\$12,532.00		Columns A & B	Expenditures To Date	Cumulative		Column C	City: Fargo	Line 2:	Address Line 1: PO Box 9859	The Village Family Service Center	Vendor/ Provider Name:
	ID IS	Activity	Progra	는	<u> </u>   	<b>1</b> L	يد	T	\$50						÷	\$3	F	1		Contra	) H		Col			PO Box 9	mily Serv	r Name:
	Туре	Resource	Program Income	\$250,000.00				\$3,759.50	\$50,000.00	\$9,984.00			\$420.00		\$146,965.50	\$1,275.00	\$37,596.00		Amendments)	(Including all	Total		Column D			859	ce Center	
	-	e Resource	Vecelved to Date	San in To Date														veboried	Previously	Allowable)	Including	Expenditures	Column E Total Matching					
			rypointed to bear	Expanded To Date													<u>.</u>	- Telion	A Bring	Allowable)	in-Kind, if	Expenditures	Column F Matching	State: ND				
	AMOUNT	TRANSACTION		Remaining Balance														Columns E & F	to Date	In-Kind, if	(Including	Matching	Column G Cumulative	Zip Code: 58106				
DISTRIBUTION:  White/Canary - Finance Canary - returned to vendor/provider with check		Date:			Liaison Accountant	Date:	しているようので		Division Director	Cate			By:	DEPAR MEN ATTROVAL	(701) 451-4864	rayee lelephone Number:	11-10-16	Date	I sombol this	Payee Signature:	X No Yes	Is this the final reimbursement request for this contract? (Please check a box)	purposes.	Department of Human Services, that matching fund requirements have been complied with and	vendor/provider organization or agency identified above and the North Dakota	an agreement betw	I hereby certify that this request accurately	PAYEE CERTIFICATION





City: Address Line 1: PO Box 9859 Vendor/ Provider Name: The Village Family Service Center Line 2: Column E Column I ND Zip Code: 58106 identified above and the North vendor/provider PAYEE CERTIFICATION organization 9

Description of Service Billing Period: Abortion From: 9/1/0156 To: 9/30/2016 From: 7/1/2016 To: 6/30/2017 Contract Period 405-10375 DHS Contract Number: Alternatives to (See reverse for instructions on completing this form) DHS FINANCE USE ONLY: CONTRACT INFORMATION LINE ᇛ Accounting Period Date REQUEST FOR REIMBURSEMENT- DIRECT SERVICE ND DEPARTMENTOF HUMAN SERVICES FISCAL ADMINISTRATION SFN 1763 (Rev. 09-2005) Supplies Speed Chart Consultation Services Totals Contractual Services Salaries & Fringe Benefit (Employees Sub-Total Administration/Indirect Costs Advertising Other (List Separately) Equipment Less Advances/Program Income raining Expenditure Classification Total Amount Requested for Reimbursement: (This billing period) Бер<u>г</u> Account Expenditures Previously Claimed Column A \$38,296.00 \$38,296.00 \$30,552.00 Class Total \$6,266.00 \$626.00 \$782.00 \$70.00 \$0.00 \$18,731.00 Expenditures This Billing Period Fund \$18,731.00 \$14,860.00 Column B Claimed \$3,133.00 \$313.00 \$390.00 \$35.00 \$0.00 Columns A & B Expenditures Cumulative Project ID \$57,027.00 \$45,412.00 Column C \$57,027.00 To Date \$9,399.00 \$1,172.00 \$105.00 \$939.00 Activity 1D Program Income Contract Award Amendments) (Including all \$146,965.50 \$250,000.00 \$37,596.00 Column D \$50,000.00 \$3,759.50 \$1,275.00 \$9,984.00 \$420.00 Resource Type **Total Matching** Expenditures eceived To Date Previously Allowable) In-Kind, if (Including Reported Resource Category Expended To Date Expenditures This Billing Period Allowable) In-Kind, if (Including Matching TRANSACTION AMOUNT to Date Columns E & F Remaining Balance Column G Cumulative (Including In-Kind, if Allowable) Expenditures Matching I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the Program Director By: Is this the final reimbursement request for this contract? (Please check a box) that such compliance is documented for audit Department of Human Services, that matching Date: Paye Signature: purposes. fund requirements have been complied with and Date: **₿** Division Director By: Payee Telephone Number: DISTRIBUTION: Liaison Accountant 701-451-4864 × S maples DEPARTMENT APPROVAL 910C-4C-01 10-, 1-16 Yes Dakota agency

**ECONOMIC ASSISTANCE** 

Canary - returned to vendor/provider

with check

retained by vendor/provider

White/Canary - Finance





			LINE Period Date	DIG HADINGE COL CALL	DHS FINANCE LISE ONLY	- 1	From: 8/1/2016 To: 8/31/2016	Billing Period:	From: 7/1/2016 To: 6/30/2017	Contract Period:							100 10010	405-10375	DHS Contract Number:				Abortion	Alternatives to		Description of Service:	CONTRACT INFORMATION		(See reverse for instructions on completing this form).	COL	los.	REQUEST ND DEPART
			Chart ID A	Sack	(This billing period)	$\cdot$	Totals	7533 Udvallocar regiant income	1,	Sub-Total	Administration/Indirect Costs	Advertising	Contractual Services	Other (List Separately)	Training	Supplies	T C C C C C C C C C C C C C C C C C C C	Eccioment	Consultation Services	Travel	Salaries & Fringe Benefit (Employees Only)	Expenditure Classification				I			n completing this form).		MINISTRATION	REQUEST FOR REIMBURSEMENT- DIRECT SERVICE ND DEPARTMENTOF HUMAN SERVICES
			Account Class		(This billing period)	r Daimhursamant:	\$18,936.00	20112	come (	\$18,936.00	\$313.00	\$0.00	\$391.00			\$35.00	200		\$15,064.00		s3,133.00		Claimed	Expenditures	Total		Coluran A					NT- DIRECT SERVI
			Fund		\$19,360.00				( )	\$19,360.00	\$313.00	\$0.00	\$391.00			\$30.00	200		\$15,488.00		\$3,133.00		Period	Claimed	Expenditures		Column B					ICE
			<b>5</b>	Project			\$38,296.00		(	\$38,296.00	\$626.00		\$782.00			\$70.00	570 00		\$30,552.00		\$6,266.00		Columns A & B	Expenditures	Cumulative		Column C	Fargo	City:	Line 2:	Address Line 1: PO Box 9859	Vendor/ Provider Name: The Village Family So
			1	Activity Resource	Program Income		\$250,000.00	L	الت		\$3,759.50	\$50,000.00	\$9,984.00			\$4£0.00	20.000		\$146,965.50	\$1,275.00	\$37,596.00		Amendments)	Contract Award	Total		Column D				PO Box 9859	Vendor/ Provider Name: The Village Family Service Center
				urce Resource	$\neg$	Received To Date	0															Reported		_	(Including	Expenditures	Total Matching	Column				ter
						Expended To Date	•															Period	This Billing	Allowable)	(Including	Li)	Matching	Clumn	State:			77
			AMOUNT	TRANSACTION		Remaining Balance																Columns E & F	to Date	In-Kind, if	(Including	Matching	Cumulative	Column G	Zip Code:			CMOMO
Pink - retained by vendor/provider	Canary - returned to vendor/provider with check	DISTRIBUTION: White/Canary - Finance		Date:		L	By:	Linicon Accountant	Date: G. レル・レフートグ	(Carvel Carted)	By:	Division Director	Care	7		∃By:	Program Director	DEPARTMENT APPROVAL	(701) 451-4864	Payee Telephone Number:	4-30-16		I'mbe to the	Payée \$ignature:	X No Yes,	Is this the final reimbursement request for this contract? (Please check a box)	purposes.	that such compliance is documented for audit	Department of Human Services, that matching	vendor/provider organization or agency lidentified above and the North Dakota	accordance with an agreement between the	ECONOMIC A Chereby Centry that this request accurately





From: 7/1/2016 To: 7/31/2016 Billing Period: Contract Period DHS Contract Number: Description of Service: DHS FINANCE USE ONLY: From: 7/1/2016 To: 6/30/2017 405-10375 Alternatives to (See reverse for instructions on completing this form) CONTRACT INFORMATION LINE NE REF Accounting Period Date REQUEST FOR REIMBURSEMENT- DIRECT SERVICE ND DEPARTMENTOF HUMAN SERVICES FISCAL ADMINISTRATION SFN 1763 (Rev. 09-2005) Speed Chart Totals Administration/Indirect Costs Other (List Separately) Supplies Consultation Services Salaries & Fringe Benefit (Employees Sub-Total Contractual Services Less Advances/Program Income Advertising Equipment raining Expenditure Classification Total Amount Requested for Reimbursement: (This billing period) Dept. Account Expenditures Previously Column A Claimed Class Total \$18,936.00 This Billing Period Expenditures Fund \$18,936.00 \$15,064.00 Column B \$3,133.00 Claimed \$391.00 \$313.00 \$35.00 \$0.00 City: Fargo The Village Family Service Center Address Line 1: PO Box 9859 Columns A & B Vendor/ Provider Name: Expenditures Project ID Cumulative \$18,936.00 \$15,064.00 Column C \$18,936.00 To Date \$3,133.00 \$313.00 \$391.00 \$35.00 Activity ID Program Income Contract Award Amendments) \$250,000.00 \$146,965.50 (Including all Column D \$37,596.00 \$50,000.00 \$3,759.50 \$9,984.00 \$1,275.00 \$420.00 Resource Type Total Matching Received To Date Expenditures (Including In-Kind, if Previously Allowable) Reported Resource Category State: Expended To Date Expenditures (Including In-Kind, If Column F This Billing Allowable) Matching TRANSACTION AMOUNT Zip Code: 58106 Remaining Balance Columns E & F Cumulative
Matching
Expenditures
(Including
In-Kind, if
Allowable) Column G to Date Date: Program Director By: DISTRIBUTION: White/Canary - Finance Date: By: Date: Is this the final reimbursement request for this contract? (Please check a box) Department of Human Services, that matching fund requirements have been complied with and Division Director By: (701) 451-4864 Payee Telephone Number purposes. that such compliance is documented for audit vendor/provider organization or agency identified above and the North Dakota reflects expenditures for services rendered in accordance with an agreement between the Payee Signature: vendor/provider Liaison Accountant hereby certify that this request accurately × No BB 8-16-2 DEPARTMENT APPROVAL PAYEE CERTIFICATION 8-10-16 Yes

265 . J. 286

72553

Pink, retained by vendor/provider

Canary - returned to vendor/provider

with check







Alternatives to Description of Service: From: 6/1/2016 To: 6/30/2016 DHS Contract Number: (See reverse for instructions on completing this form) Billing Period: From: 7/1/2015 To: 6/30/2016 Contract Period: 405-08616 CONTRACT INFORMATION DHS FINANCE USE ONLY: LINE Accounting Period Date REQUEST FOR REIMBURSEMENT- DIRECT SERVICE ND DEPARTMENTOF HUMAN SERVICES FISCAL ADMINISTRATION SFN 1763 (Rev. 09-2005) Salaries & Fringe Benefit (Employees Other (List Separately) Training Supplies Equipment Consultation Services Speed Chart Totals Administration/Indirect Costs Contractual Services Sub-Total Advertising Less Advances/Program Income Expenditure Classification Total Amount Requested for Reimbursement: (This billing period) □ pt Account Expenditures \$158,138.00 \$200,811.00 \$200,811.00 Previously Column A \$34,463.00 Class \$3,443.00 \$4,298.00 \$386.00 \$83.00 \$23,442.00 Expenditures This Billing Period Fund \$19,512.00 Column B \$23,442.00 Claimed \$3,133.00 \$313.00 \$449.00 \$35.00 \$0.00 City: Fargo Vendor/ Provider Name: Address Line 1: PO Box 9859 Columns A & B Cumulative Expenditures The Village Family Service Center \$177,650.00 \$224,253.00 Project ID Column C \$224,253.00 \$37,596.00 To Date \$4,747.00 \$3,756.00 \$421.00 \$83.00 Line 2: Activity Program Income Contract Award Amendments) (Including all \$146,965.50 \$250,000.00 Column D \$37,596.00 \$50,000.00 \$1,275.00 \$3,759.50 \$9,984.00 \$420.00 Resource Type Total Matching Expenditures eceived To Date Allowable) In-Kind, if Previously (Including Column E Reported Resource Category State Expended To Date In-Kind, if Allowable) This Billing Expenditures (Including Matching Column F Period S TRANSACTION AMOUNT Zip Code: 58106 Expenditures
(Including
In-Kind, if
Allowable)
to Date Columns E & F Remaining Balance Cumulative Column G Matching ECONOMIC ASSESTANCE reflects expenditures for services rendered in accordance with an agreement between the Is this the final reimbursement request for this contract? (Please check a box) that such compliance is documented for audit fund requirements have been complied with and Department of Human Services, that matching purposes. identified above and the North Dakota vendor/provider Ş Payee/Signature: Division Director By: Payee Telephone Number Date: **Program Director** (701) 451-4864 Date By: Liaison Accountant hereby certify that this request accurately DISTRIBUTION: N O DEPARTMENT APPROVAL Miles 7-11-0016 7-7-16 organization ×Yes N S

Canary - returned to vendor/provider

with check

White/Canary - Finance

Pink - retained by vendor/provider

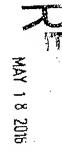


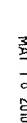


Alternatives to Description of Service: 405-08616 DHS Contract Number: Abortion (See reverse for instructions on completing this form) From: 5/1/2016 To: 5/31/2016 Contract Period: CONTRACT INFORMATION DHS FINANCE USE ONLY: Billing Period: From: 7/1/2015 To: 6/30/2016 LINE Accounting Period Date REQUEST FOR REIMBURSEMENT- DIRECT SERVICE ND DEPARTMENTOF HUMAN SERVICES FISCAL ADMINISTRATION SFN 1763 (Rev. 09-2005) Consultation Services Salaries & Fringe Benefit (Employees Speed Chart Contractual Services Supplies Equipment Totals Sub-Total Training Advertising Other (List Separately) Less Advances/Program Income Administration/Indirect Costs Expenditure Classification Total Amount Requested for Reimbursement:
(This billing period) ⊒ pep Account Expenditures \$185,339.00 \$146,538.00 \$185,339.00 Column A Previously \$31,330.00 Claimed Class \$3,907.00 Total \$3,130.00 \$351.00 \$83.00 \$15,472.00 This Billing Period Expenditures Column B \$11,600.00 Fund \$15,472.00 Claimed \$3,133.00 \$313.00 \$391.00 \$35.00 \$0.00 City: Fargo Vendor/ Provider Name: Expenditures
To Date Address Line 1: PO Box 9859 Columns A & B The Village Family Service Center \$158,138.00 Cumulative \$200,811.00 Project ID \$200,811.00 Column C \$34,463.00 \$4,298.00 \$3,443.00 \$386.00 \$83.00 Line 2: Activity Program Income Amendments) Contract Award (Including all \$146,965.50 \$250,000.00 \$37,596.00 Column D \$50,000.00 \$1,275.00 \$9,984.00 \$3,759.50 Total \$420.00 Resource Type **Total Matching** Expenditures Received To Date Previously Allowable) Reported In-Kind, if (Including Column E Resource Category Expenditures Expended To Date This Billing Allowable) In-Kind, if (Including Matching Column F Period 8 TRANSACTION AMOUNT Zip Code: 58106 Columns E & F Column G Cumulative Matching Expenditures Remaining Balan (Including In-Kind, if Allowable) to Date Is this the final reimbursement request for this contract? (Please check a box)

X No Yes reflects expenditures for services rendered in accordance with an agreement between the I hereby certify that this request accurately that such compliance is documented for audit Department of Human Services, that matching fund requirements have been complied with and reflects expenditures for services rendered Date: Payee Telephone Number Payee \$ignature: purposes. identified above and the North vendor/provider organization ₿ .: **Division Director** Program Director By: (701) 451-4864 В<u>у</u>: Canary - returned to vendor/provider with check White/Canary - Finance DISTRIBUTION: Date: Liaison Accountant DEPARTMENT APPROVAL PAYEE CERTIFICATION 1-41-0 Dakota agency

Pink - retained by vendor/provider







Pink - retained by vandor/provider											
Canary - returned to vendor/provider				1				+			
White/Canary - Finance											
DISTRIBUTION:											
Date:	TRANSACTION AMOUNT		Resource Category	ity Resource Type	Project Activity	Fund	Class	Account	Speed Dept. Chart ID	Accounting Period Date	LINE
	ŕ			lam!		\$23,727.00	This bitting period)			DHS FINANCE USE ONLY:	DHS FIN
	<ul> <li>Remaining Balance</li> </ul>	Expended To Date	Received To Data				ursement	stad for Reimb	Total Amount Requested for Reimburgement:		
By:				\$250,000.00	\$185,339.00		\$161,612.00		Totats	To: 4/30/2016	From: 4/1/2016
ケーダシの守						) (		ram Income	Less Advances/Program Income		Billing Period:
Date:						,				To: 6/30/2016 -	From: 7/1/2015
Canal Cardon					\$185,339.00	\$23,727.00	\$161,612.00		Sub-Total		Contract Period
By:				\$3,759.50	\$3,130.00	\$313.00	\$2,817.00	Costs	Administration/Indirect Costs	1	
Division Director				\$50,000.00	\$83.00		\$83.00		Advertising	I %	
Date:				\$9,984.00	\$3,907.00	\$332.00	\$3,575.00	is.	Contractual Services	Io.	
									Other (List Separately)	10	
									Training	14	
Program Director				\$420.00	\$351.00	\$35,00	\$316.00		Supplies	Im	
DEPARTMENT APPROVAL									Equipment		405-08616
(701) 451-4864				\$146,965.50	\$146,538.00	\$19,914.00	\$126,624.00		Consultation Services	DHS Contract Number: C	DHS Contr
Payee Telephone Number:				\$1,275.00					Travel	Ta T	
5-16-16 C				\$37,596.00	\$31,330.00	\$3,133.00	\$28,197.00	(Empoyees	Salanes & Fringe Benefit (Empoyees	To on	
Paylor Signature: Paylor Signa	(Including in-Kind, if Allowable) to Date Columns E & F	In-Kind, if Nicwable) This Billing Period	in-Kind, if Allowable) Previously Reported	iotal Contract Award [Including all Amendments]	Expenditures C To Date Columns A & B	Claimed E This Billing Period Co	Expenditures Previously Ctalmed	fication	Expenditure Classification		Alternatives to Abortion
is this the final reimbursement request for this contract? (Please check a box)	Matching Expanditures	Expenditures	Expenditures				[			of Service:	Description of Service
that such compliance is documented for audit purposes.	Column G	Column F	Column E Total Matching	Column D	Column C	Column B	Column A			CONTRACT INFORMATION	CONTRA
Department of Human Services, that matching fund requirements have been compiled with and	Zip Code: 58106	State: ND			City: Fargo	City: Farq			mpleting this form).	(See reverse for instructions on completing this form).	(See revers
vendon/hovider organization or agency					Line 2	-			,		
reflects expenditures for services rendered in accordance with an excement between the				Box 9859	Address Line 1: PO Box 9859	ı			ISTRATION 2005)	FISCAL ADMINISTR	
PAYEE CERTIFICATION  I hereby certify that this request accurately			,	ne: Service Center	Vendor/ Provider Name: The Village Family Service Center	1	RECT SERVI	EMENT- DI	REQUEST FOR REIMBURSEMENT- DIRECT SERVICE ND DEPARTMENTOF HUMAN SERVICES	ND DEPARTME	
						, (				,	





(See

	REQUEST FOR REIMBURSEMENT- DIRECT SERVICE ND DEPARTMENTOF HUMAN SERVICES	MENT- DII	RECT SERVI	CE CE	Vendor/ Provider Name: The Village Family Se	Vendor/ Provider Name: The Village Family Service Center	<u> </u>			PAYEE CERTIFICATION  I hereby certify that this request accurately
0,0	SFN 1763 (Rev. 09-2005)	•.			Address Line I. PO Box 9859	PO Box 9859				accordance with an agreement between the
( many					Line 2:					vendor/provider organization or agency
(See reverse for instructions on completing this form).	completing this form).				City: Fargo			State: ND	Zip Code: 58106	Department of Human Services, that matching fund requirements have been complied with and
CONTRACT INFORMATION			Column A	Column B	Column C	Column D	Column E	Column F Matching	Column G Cumulative	that such compliance is documented for audit purposes.
Description of Service:							Expenditures	Expenditures	Matching	Is this the final reimbursement request for this contract? (Please check a box)
Alternatives to			Total	Expenditures	Cumulative	Total	In-Kind, if	In-Kind, if	(Including	X No ☐ Yes
Abortion			Previously	This Billing	To Date	(Including all	Allowable)	Allowable)	Allowable)	Payée \$ignature:
	Expenditure Classification	ğ 	Claimed	Period	Columns A & B	Amendments)	Reported	Period	to Date	Comper Chistery
	Salaries & Fringe Benefit (Employees Only)	ployees	\$25,064.00	\$3,133.00	\$28,197.00	\$37,596.00				4-16-16
	Travel					\$1,275.00				Payee Telephone Number:
DHS Contract Number:	Consultation Services		\$108,380.00	\$18,244.00	\$126,624.00	\$146,965.50				4984-15H-10L
405-08616	Equipment									DEPARTMENT APPROVAL
	Supplies		\$281.00	\$35.00	\$316.00	\$420.00				Program Director
	Training									
	Other (List Separately)									
	Contractual Services		\$3,126.00	\$449.00	\$3,575.00	\$9,984.00				Cate
	Advertising		\$83.00		\$83.00	\$50,000.00				Division Director
	Administration/Indirect Costs	8	\$2,504.00	\$313.00	\$2,817.00	\$3,759.50				) By:
Contract Period:	Sub-Total		\$139,438.00	\$22,174.00	\$161,612.00	<b></b>				Carol Cartles
From: 7/1/2015 To: 6/30/2016 Billing Period:	Less Advances/Program Income	Income	<u> </u>	( )	î					Date: 4-8.1016
From: 3/1/2016 To: 3/31/2016	Totals		\$139,438.00		\$161,612.00	\$250,000.00				By:
DHS FINANCE USE ONLY:	Total Amount Requested for Reimbursement: (This billing period)	d for Reimbu (T	rsement: his billing period)	\$22,174.00	<u></u>	Program Income	Received to Date	Expended to Date	Remaining balance	
REF Accounting Period Date	Speed Dept.	Account	Class	Fund	Project ID	Activity Resource	rce Resource Category		TRANSACTION AMOUNT	Date:
CITE	+									

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider





LINE Period Date	- NA		From: 2/1/2016 To: 2/29/2016	- 1	From: 7/1/2015 To: 6/30/2016	Contract Period:						405-08616	DHS Contract Number:			Abortion	Alternatives to	Description of Service:	CONTRACT INFORMATION	(See levelse iol instructions on completing this form)		410	ND DEPAI	
Chart ID Account		Total Amount Requested for Reimbursement:	卢	Less Advances/Program Income	т	Administration/Indirect Costs	Advertising	Contractual Services	Other (List Separately)	Training	Supplies	Equipment	Consultation Services	Travel	Only)	Expenditure Classification			Z	on completing this form).		SFN 1763 (Rev. 09-2005)	REQUEST FOR REIMBURSEMENT- DIRECT SERVICE ND DEPARTMENTOF HUMAN SERVICES FISCAL ADMINISTRATION	
Class	This billing period)	ursement:	\$125,852.00	( )	\$125,852.00	\$2,191.00	\$83.00	\$2,677.00			\$246.00		\$98,724.00		\$21,931.00	Claimed	Total Expenditures		Column A				DIRECT SERV	
Fund	\$13,586.00			)	\$13,586.00	\$313.00		\$449.00			\$35.00		\$9,656.00		\$3,133.00	Period	Expenditures Claimed		Column B				/ICE	
Project Ac			\$139,438.00	( )	\$139,438.00	\$2,504.00	\$83.00	\$3,126.00			\$281.00		\$108,380.00		\$25,064.00	Columns A & B	Cumulative Expenditures		Column C	City: Fargo	Line 2:	Address Line 1: PO Box 9859	Vendor/ Provider Name: The Village Family Se	
Activity Resource	Program Income		\$250,000.00			\$3,759.50	\$50,000.00	\$9,984.00			\$420.00		\$146,965.50	\$1,275.00	\$37,596.00	Amendments)	Total Contract Award		Column D			PO Box 9859	Vendor/ Provider Name: The Village Family Service Center	
e Resource Category		Received To Date														Previously Reported	(Including In-Kind, if Allowable)	Expenditures	Column E				3.	
TRANS		Expended To Date														This Billing Period	(Including III-Kind, if Allowable)	Matching Expenditures	Column F	State: ND				
TRANSACTION AMOUNT		Remaining Balance														Allowable) to Date Columns E & F	(Including In-Kind, if	Matching Matching	Column G	Zip Code: 58106				
Date:		by:	Liaison Accountant	Date: <b>3-18-16</b>	alen dure	By:	Division Director	Date:		вy:	œΙ	DEPARTMENT APPROVAL	(701) 451-4864	Payee Telephone Number:	Date: 3-15-16	amberbludy	X No Yes	ls this the final reimbursement request	that such compliance is documented for audit	Identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and	organizatio	reflects expenditures for services rendered in	PAYEE CERTIFICATION  I hereby certify that this request accurately	ECONOMIC ASSISTANCE

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider
with check
Pink - retained by vendor/provider











11	FOR REIMBURSEMEN	VT- DIRECT SERV	ACE.	Vendor/ Provider Name	Name:				PAYEE CERTIFICATION
ND DEPART	ND DEPARTMENTOF HUMAN SERVICES	S		THe Village Fa	THe Village Family Service Center	· ·			I hereby certify that this request accurately
0,013	AINISTRATION			Address Line 1: PO Box 9859	O Box 9859				reflects expenditures for services rendered in accordance with an agreement between the
				Line 2:					vendoriprovider organization or agency
(See reverse for instructions on completing this form).	completing this form).			City: Fargo			State: ND	Zip Code: 58106	Department of Human Services, that matching fund requirements have been compiled with and
CONTRACT INFORMATION	•	Column A	Column B	Column C	Column D	Column E	Column F	Column G Cumulative	that such compliance is documented for audit purposes.
Description of Service:		-				Expenditures	Expenditures	Matching	Is this the final reimbursement request
		Total	Expenditures	Cumulative	Total	(Including	Including	Expenditures (Including	X No Yes
Alternatives to		Previously	Claimed This Billing	Expenditures To Date	Contract Award	Allowable)	Allowable)	In-Kind, if	Payee Signature:
Abortion	Expenditure Classification	Claimed	Period	Columns A & B	Amendments)	Previously Reported	This Billing Period	to Date	Ember Jouly
	Salaries & Fringe Benefit (Employees Only)	* \$15,665.00	\$3,133.00	\$18,798.00	\$37,596.00				1-19-16
	Travel	:			\$1,275.00				Payee Telephone Number:
DHS Contract Number:	Consultation Services	\$73,436.00	\$11,812.00	\$85,248.00	\$146,965.50				(701) 451-4864
405-08616	Equipment								DEPARTMENT APPROVAL
	Supplies	\$176.00	\$35.00	\$211.00	\$420.00		-		Program Director
	Training								Ç
	Other (List Separately)	1							
	Contractual Services	\$1,954.00	\$391.00	\$2,345.00	\$9,984.00				Date:
	Advertising	\$83.00	\$0.00	\$83.00	\$50,000.00				Division Director
	Administration/Indirect Costs	\$1,565.00	\$313.00	\$1,878.00	\$3,759.50				By:
Contract Period:	Sub-Total	\$92,879.00	\$15,684.00	\$108,563.00					(CHA) CHELODO
From: 7/1/2015 To: 6/30/2016	Less Advances/Program Income	ome (	^ 	<u>`</u>					Date: 1-1-1-0-1
	T0+2	00 020		6400 500 00	5250 000 00				Liaison Accountant
1 1011. 12/1/2013 10: 12/01/2013	T	Reimbursement:	ლ			Received To Date	Expended To Date	Remaining Balance	by.
DHS FINANCE USE ONLY:	(This billing period)	(This billing period)	\$15,684.00		ram I				
REF Accounting LINE Period Date	Speed Dept. Ac	Account Class	Fund	Project A	Activity Resource	ce Resource Category		AMOUNT	Date:
						_			

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider
with check
Pink - retained by vendor/provider

## DEC 18 2015





	T FOR REIMBURSEMEN	T- DIRECT SERV	ACE	Vendor/ Provider Name:	Name:				PAYER CERTIFICATION
FISCAL ADI	FISCAL ADMINISTRATION		TANOT	The Village Far	The Village Family Service Center	Ĭ			I hereby certify that this request accurately
11/0	v. 09-2005)	CI CITIC NO.	MANCE	Address Line 1: PO Box 9859	PO Box 9859				reflects expenditures for services rendered in accordance with an agreement between the
				Line 2:					organization or
(See reverse or insurctions on completing this form).	n completing this form).			City: Fargo			State: ND	Zip Code: 58106	Department of Human Services, that matching
CONTRACT INFORMATION		Column A	Column B	Column C	Column D	Column E		Column G	that such compliance is documented for audit
Description of Service:		, · · , · · · · · · · · · · · · · · · ·			***************************************	Expenditures	Expenditures	Matching	Is this the final reimbursement request
Alternatives		Total	Expenditures	Cumulative.	Total	(Including	(Including	Expenditures (Including	x No Yes
to Abortion		Previously	This Billing	Expenditures To Date	(Including all	Allowable)	Allowable)	In-Kind, if	nature:
	Expenditure Classification	Claimed	Period	Columns A & B	Amendments)	Reported	Period	to Date	1 mor Husters
	Salaries & Fringe Benefit (Employees Only)	\$12,532.00	\$3,133.00	\$15,665.00	\$37,596.00			1	Date: 12-15-15
	Travel				\$1,275.00				Payee Telephone Number:
DHS Contract Number:	Consultation Services	\$59,808.00	\$13,628.00	\$73,436.00	\$146,965.50				(701) 451-4864
405-08616	Equipment								DEPARTMENT APPROVAL
	Supplies	\$141.00	\$35.00	\$176.00	\$420.00				Program Director
	Training								ŗ,
	Other (List Separately)								
	Contractual Services	\$1,563.00	\$391.00	\$1,954.00	\$9,984.00				Date:
	Advertising	\$83.00	\$0.00	\$83.00	\$50,000.00				Division Director
	Administration/Indirect Costs	\$1,252.00	\$313.00	\$1,565.00	\$3,759.50				By:
	Sub-Total	\$75,379.00	\$17,500.00	\$92,879.00					for stilling
Billing Period:	Less Advances/Program Income	ne ( )	( )	)		•			Date: 12/2/12015
From: 11/1/2015 To: 11/30/2015	Totals	\$75,379.00		\$92,879.00	\$250,000.00				Liaison Áccoúntant
	Total Amount Requested for Reimbursement:	eimbursement:	27 500 00			Received To Date	Expended To Date	Remaining Balance	
₹		(Trits billing period)	\$17,500.00		Program Income				
LINE Period Date	Speed Dept. Account	unt Class	Fund	Project A	Activity Resource	e Resource Category		TRANSACTION AMOUNT	Date:
					-				White/Canary - Finance
									Canary - returned to vendor/provider with check
									Dink - retained by vendor/provider





Vendor/ Provider Name:

Alternatives to Abortion DHS FINANCE USE ONLY: From: 10/1/2015 To: 10/31/2015 From: 7/1/2015 To: 6/30/2016 DHS Contract Number: Contract Period: 405-08616 Description of Service: (See reverse for instructions on completing this form) CONTRACT INFORMATION LINE RE Accounting Period Date REQUEST FOR REIMBURSEMENT- DIRECT SERVICE ND DEPARTMENTOF HUMAN SERVICES FISCAL ADMINISTRATION SFN 1763 (Rev. 09-2005) Totals Speed Chart Training Contractual Services Supplies Equipment Salaries & Fringe Benefit (Employees Sub-Total Administration/Indirect Costs Advertising Other (List Separately) Consultation Services Less Advances/Program Income Expenditure Classification Total Amount Requested for Reimbursement: (This billing period) E pt. Account Previously Claimed Expenditures Column A \$57,575.00 \$57,575.00 \$45,876.00 Class \$1,173.00 \$9,399.00 \$939.00 \$105.00 \$83.00 \$17,804.00 Expenditures This Billing Period Fund \$17,804.00 \$13,932.00 Column B \$3,133.00 \$390.00 \$313.00 \$36.00 \$0.00 City: Fargo Address Line 1: PO Box 9859 Columns A & B The Village Family Service Center Expenditures Project ID Cumulative \$75,379.00 \$59,808.00 \$12,532.00 Column C \$75,379.00 \$1,252.00 \$1,563.00 \$141.00 \$83.00 Line 2: Activity ID Total Contract Award Program income Amendments) \$250,000.00 (Including all \$146,965.50 \$50,000.00 \$37,596.00 Column D \$3,759.50 \$9,984.00 \$1,275.00 \$420.00 Resource Type **Total Matching** Expenditures Received To Date Previously Allowable) Column E Reported In-Kind, if (Including Resource Category Expended To Date In-Kind, if Allowable) Expenditures This Billing (Including Column F Matching TRANSACTION ECONOMIC ASSISTANCE Zip Code: 58106 Remaining Balance Columns E & F Expenditures Cumulative Allowable) Matching Column G In-Kind, if (Including to Date By: Date: Program Director By: Department of Human Services, that matching fund requirements have been complied with and Date: Is this the final reimbursement request for this contract? (Please check a box) that such compliance is documented for audit I hereby certify that this request accurately DISTRIBUTION: White/Canary - Finance Liaison Accountant **Division Director** (701) 451-4864 Payee Telephone Number: Payee Signature: purposes. vendonprovider o accordance with an agreement between the reflects expenditures for services rendered in X DEPARTMENT APPROVAL 1-12organization and the North Dakota

Pink - retained by vendor/provider Canary - returned to vendor/provider

with check







			LINE Period Date	Ž		From: 9/1/2015 To: 9/30/2015		From: 7/1/2015 To: 6/30/2016	Contract Period:						405-08616	DHS Contract Number:				Abortion	Alternatives to	a section of on along	Description of Service.	CONTRACT INFORMATION	(See level se for instructions on completing this form).	(Soo 5) 100 for in-	7.5	ND DEPART
			Speed Dept. Account Chart ID Account		Total Amount Requested for Reimbursement:	Totals	Less Advances/Program Income	Sub-Total	Administration/Indirect Costs	Advertising	Contractual Services	Other (List Separately)	Training	Supplies	Equipment	Consultation Services	Travel	Only)	Expenditure Classification Salanes & Fringe Benefit / Employee						completing this form).		v. 09-2005)	NE GOGIA FOR A CIMBURSEMENT DIRECT SERVICE ND DEPARTMENTOR HUMAN SERVICES FISCAL ADMINISTRATION
			nt Class		_	\$40,616.00	e (	\$40,616.00	\$626.00	\$0.00	\$782.00			\$70.00		\$32,872.00		\$6,266.00		Claimed	Expenditures		Column A					F- DIRECT SERV
			Fund	\$16,959.00	246 020		(	\$16,959.00	\$313.00	\$83.00	\$391.00			\$35.00		\$13,004.00		\$3,133.00		This Billing	Expenditures Claimed		Column B					ÎCE
			Project A			\$57,575.00	( )	\$57,575.00	\$939.00	\$83.00	\$1,173.00			\$105.00		\$45,876.00		\$9,399.00	000000000000000000000000000000000000000	To Date	Cumulative Expenditures		Column C	Fargo	City:	Line 2:	Address Line 1: PO Box 9859	Vendor/ Provider Name: The Village Family Se
			Activity Resource	Program Income		\$250,000.00			\$3,759.50	\$50,000.00	\$9,984.00			\$420.00		\$146,965.50	\$1,275.00	\$37,596.00	Cancillatine Its)	(Including all	Total Contract Award		Column D				PO Box 9859	Jendor/ Provider Name: The Village Family Service Center
			ce Resource Category		Received To Date														Reported	Previously		Expenditures	Total Matching	2				ler
					Expended To Date														Period	This Billing	In-Kind, if	Expenditures	Column F	ND	State:			
			TRANSACTION AMOUNT	•	Remaining Balance														to Date Columns E & F	Allowable)	(Including	Matching	Column G	58106	Zip Code:			
Pink - retained by vendor/provider	Canary - returned to vendor/provider with check	DISTRIBUTION: White/Canary - Finance	Date:		Cy.	Liaison Accountant	Date: 10-19-2015	Canol Centle & o	By:	Division Director	Date:		- By:	Program Director	DEPARTMENT APPROVAL	(701) 451-4864	Payee Telephone Number:	Date: 10-12/5	ember suelen	ayee signature:	X No Yes	is this the final reimbursement request	that such compliance is documented for auc purposes.	fund requirements have been complied with an	identified above and the North Dakot	vendor/provider organization or agent	reflects expenditures for services rendered	PAYEE CERTIFICATION  hereby certify that this request accurate

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		REF Accounting LINE Period Date	DHS FINANCE USE ONLY:	- 1	From: 8/1/2015 To: 8/31/2015	Billing Period: 6/30/2016								405-08616	DHS Contract Number:				Alternatives to		Description of Service:	CONTRACT INFORMATION	( oee levelse in mannennis on completing mis ionii).	(So reverse for instructions as	SFN 1763 (Rev. 09-2005)	ECONOMICASSI ND DEPART
		Speed Dept. Account	lotal Amount Requested for Reimbursement: (This billing period)		Totals	Less Advances/Program Income	Sub-Total	Administration/Indirect Costs	Advertising	Contractual Services	Other (List Separately)	Training	Supplies	Equipment	Consultation Services	Travel	Salaries & Fringe Benefit (Employees Only)	Expenditure Classification					completing this form).		4. 09-2005)	ND DEPARTMENTO HUMAN SERVICES
		Class	(This billing period)		\$20,852.00	( )	\$20,852.00	\$313.00	\$0.00	\$391.00			\$35.00		\$16,980.00		\$3,133.00	Clailled	Previously	Expenditures	•	Column A				DIRECT SERV
		Fund	\$19,764.00			( )	\$19,764.00	\$313.00		\$391.00	:		\$35.00		\$15,892.00		\$3,133.00	rendu	This Billing	Claimed	1	Column B				1CE
		Project A			\$40,616.00	( )	\$40,616.00	\$626.00		\$782.00			\$70.00		\$32,872.00		\$6,266.00	Column A & B	To Date	Expenditures		Column C	Fargo	Line 2:	Address Line 1: PO Box 9859	Vendor/ Provider Name: The Village Family Se
		Activity Resource	Program Income		\$250,000.00			\$3,759.50	\$50,000.00	\$9,984.00			\$420.00		\$146,965.50	\$1,275.00	\$37,596.00	Allielidilielis)	(Including all	Contract Award	!	Column D			O Box 9859	Vendor/ Provider Name: The Village Family Service Center
		Resource Category	_	Received To Date														Reported	Previously	In-Kind, if	Expenditures	Column E Total Matching				34
				Expended To Date														Period	This Billing	h-Kind, if	Expenditures (Including	Column F Matching	State: ND			
		TRANSACTION AMOUNT		Remaining Balance														Columns E & F	Allowable)	(Including	Matching Expenditures	Column G Cumulative	Zip Code: 58106			
White/Canary - Finance Canary - returned to vendor/provider with check Pink - retained by vendor/provider	DISTRIBUTION:	Date:			Liaison Accountant	Date: 09-17-2015 1	Carul Coulled	By.	Division Director	Date:			Program Director	DEPARTMENT APPROVAL	(701) 451-4864	Payee Telephone Number:	Date: 9-14-15	CHIEC STRAKE		X No Yes	Is this the final reimbursement request for this contract? (Please check a box)	that such compliance is documented for audit purposes.	int of Human Services, that rements have been complied	vendor/provider organization or agency identified above and the North Dakota	reflects expenditures for services rendered in accordance with an agreement between the	PAYEE CERTIFICATION I hereby certify that this request accurately



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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE	DIRECT SERV	CH H	Vendor/ Provider Name:	vame:				PAYEE CERTIFICATION
ND DEPARTMENTOF HUMAN SERVICES			The Village Fam	The Village Family Service Center				hereby certify that this request accurately
FISCAL ADMINISTRATION SFN 1763 (Rev. 09-2005)			Address Line 1: PO Box 9859	O Box 9859				reflects expenditures for services rendered in accordance with an agreement between the
			Line 2:					vendor/provider organization or agency
On recognition of population this torm			2				7	identified above and the North Dakota
see leverse or instructions on completing this form).			C.P.			State:	ZIP Code:	Department of Human Services, that matching
			Fargo			ND	58106	fund requirements have been complied with and
CONTRACT INFORMATION		) -	)	)	Column E	Column F	Column G	that such compliance is documented for audit
	Column A	Column B	Column C	Column D	Total Matching	Matching	Cumulative	purposes.
Description of Service:					Expenditures	Expenditures	Matching	Is this the final reimbursement request
	Total	Expenditures	Cumulative	Total	(Including	(Including	Expenditures	TOP this contract: (Please check a box)
	Expenditures	Claimed	Expenditures	Contract Award	in-Kind, ii	in-Ning, it	n-Kind. if	
Alternatives to Abortion	Previously	This Billing	To Date	(Including all	Allowable)	Allowable)	Allowable)	Spec Signamic
Georgia o Charles	Claimed	Period	Columns A & B	Amendments)	Reported	Period	to Date	Chief day
Expenditure Classification					1000000		Columns E & F	

REQUEST	FOR REIMBURSEMENT-	DIRECT SERV		Vendor/ Provider Name:	lame:				PAYEE CERTIFICATION
	FISCAL ADMINISTRATION			The Village Family Service C	The Village Family Service Center	Ä			hereby certify that this request accurately reflects expenditures for services rendered in
	. 09-2005)		-		C DOX SOUS	***************************************			accordance with an agreement between the
			-	Line 2:					vendor/provider organization or agency identified above and the North Dakota
(See reverse for instructions on completing this form)	completing this form).			City: Fargo			State: ND	Zip Code: 58106	nt of Human Services, that rements have been complied to
CONTRACT INFORMATION		Column A	Column B	Column C	Column D	Column E	Column F	Column G Cumulative	that such compliance is documented for audit purposes.
Description of Service:	•	-				Expenditures	Expenditures	Matching	Is this the final reimbursement request
		Total	Expenditures	Cumulative	Total	(Including In-Kind, if	(Including In-Kind, if	(Including	No Yes
Alternatives to Abortion		Previously	<u> </u>	To Date	(Including all	Allowable) Previously	Allowable) This Billing	Allowable)	Payee Signature:
	Expenditure Classification	Claimed	Period	Columns A & B	Amenaments)	Reported	Period	Columns E & F	MILES Servey
	Salaries & Fringe Benefit (Employees Only)	\$0.00	\$3,133.00	\$3,133.00	\$37,596.00				P-17-15
•	Travel	\$0.00	\$0.00		\$1,275.00				Payee Telephone Number:
DHS Contract Number:	Consultation Services	\$0.00	\$16,980.00	\$16,980.00	\$146,965.50				(701) 451-4864
405-08616	Equipment								DEPARTMENT APPROVAL
	Supplies	\$0.00	\$35.00	\$35.00	\$420.00				Program Director
	Training								Ş
	Other (List Separately)								
	Contractual Services	\$0.00	\$391.00	\$391.00	\$9,984.00				Date:
	Advertising	\$0.00	\$0.00		\$50,000.00				Division Director
And the state of t	Administration/Indirect Costs	\$0.00	\$313.00	\$313.00	\$3,759.50				, <u>R</u>
Contract Period:	Sub-Total		\$20,852.00	\$20,852.00					( mal Castlodo?
Billing Period: 6/30/2016	Less Advances/Program Income	( )	( )	^ )		,			Date: 8 - 19 10 10
From: 7/1/2015 To: 7/31/2015	Totals			\$20,852.00	\$250,000.00				By:
	Total Amount Requested for Reimbursement:	nbursement:				Received To Date	Expended To Date	Remaining Balance	•
DHS FINANCE USE ONLY:		(This billing period)	\$20,852.00		Program Income				
REF Accounting LINE Period Date	Speed Dept. Account Chart ID	ıt Class	Fund	Project Ac	Activity Resource	ce Resource Category		TRANSACTION AMOUNT	Date:
									DISTRIBUTION:
									Capant - returned to vendor/provider
									with check
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